Exhibit A

IN THE U. S. DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

JOHNNY W. SASSER,
PLAINTIFF,
VS. CASE NO: 2:06-CV-593-CSC
RYDER TRUCK RENTAL, et al.,
DEFENDANTS.

The deposition of DR. J. JERRY MARSELLA, JR., taken by the Plaintiff, pursuant to the Federal Rules of Civil Procedure, before Stacey Watkins, RPR, and Notary Public, State at Large, at the offices of Anesthesia Consultants Medical Group, Dothan, Alabama, on the 20th day of July, 2007, at 7:10 a.m., CDT, pursuant to notice.

* * * * *

APPEARANCES:

FOR THE PLAINTIFFS:
MS. AMY M. SHUMATE
Attorney at Law
Dothan, Alabama

FOR THE DEFENDANTS:
MR. CONLEY W. KNOTT
Attorney at Law
Birmingham, Alabama

ALSO PRESENT:
JOHNNY SASSER

STIPULATION

It is stipulated by and between counsel for the parties that this deposition be taken at this time by Stacey Watkins, RPR, and Notary Public, State at Large, who is to act as commissioner without formal issuance of commission to her; that said deposition shall be taken down stenographically, transcribed, and certified by the commissioner. The signature of the witness is waived.

Except for objections as to the form of questions, no objections need be made at the time of the taking of the deposition by either party, but objections may be interposed by either party at the time the deposition is read into evidence, which shall be ruled upon by the Court on the trial of the cause upon the grounds of objection then and there assigned.

DR. J. JERRY MARSELLA, JR.
having been first duly sworn, testified as follows, to-wit:

EXAMINATION

BY MS. SHUMATE:

Q Dr. Marsella, my name is Amy Shumate, and I represent Johnny Sasser in a lawsuit that's been filed regarding his workers' comp claim. I'm going to be asking you questions. And, of course, I know you've done this before. But, if, at any time, you don't understand the question, certainly let me know --

A Certainly.

Q -- and I can rephrase it. Would you please state your name for the record?

A John Jerry Marsella, Jr.

MS. SHUMATE: And for the record, the attorneys have stipulated, prior to going on the record, Dr. Marsella's qualifications as a physician and his licensing, and we have agreed

to attach his CV to this deposition as Plaintiff's Exhibit No. 1.

Q Now, I would like to ask you a couple of questions about your specialty. You are a physician, licensed in Alabama? Correct?

A Yes.

Q Do you have an area of specialty in medicine that you practice in?

A My primary specialty is anesthesiology, and my subspecialty is pain management.

Q Okay. Now, what, specifically, does it mean to have a subspecialty in pain management?

A That implies extra training in that area, in this case, pain management, which, in my case, was a six-month postgraduate fellowship with concentration in all aspects of pain medicine and pain management.

Q And what does a pain management doctor do? What do you do for your patients?

A We handle, primarily, chronic pain problems, but we also do some acute

postoperative pain management. The chronic pain problems are anything from back pain to headache to special types of nerve pain to basically all kind of pain. We manage those by using various techniques and methods, including injections, physical therapy, occupational therapy, medications.

Q So, is it a fair statement that you're not necessarily in the business of curing the problem, but helping them live with the pain that's associated with it?

A Yes.

Q Okay. And are you board certified in anesthesiology?

A I am.

Q Is there a board certification for pain management?

A Yes, there is, and I'm board certified.

Q All right. Is that a separate certification?

A It is.

Q How long have you practiced in the area of pain management?

A In private practice 16 years.

Q All right. Now, you have had an occasion to see and treat Mr. Johnny Sasser? Is that correct?

A I have.

Q Can you tell the jury when the first time was that you saw Mr. Sasser, and what the reason for his visit was?

A Mr. Sasser's first visit here, not in this particular building, but with our practice, was on September the 5th of the year 2000. He came in with the chief complaint of low back pain, had diagnosis of degenerative disc disease of the lumbar spine and lumbar spinal stenosis.

The history that he gave was that he had been dealing with his pain since 1995, at which time he said that he was doing his usual work, and he was helping to lift a motor, an 800-pound motor, at the General Electric plant. And while he was attempting to lift the motor and secure it, he strained his back, and since that time, he had had the back pain and the problems with his back.

Q Okay. Now, to bring you up to speed, so you'll know what we're doing here

today, Mr. Sasser had already settled his case with the workers' comp company regarding that back injury, and they were ordered to continue to pay medical treatment that was related to that back injury on the job.

Now, was he referred to you by another physician?

A Let me look.

Q Sure.

A Typically, they are. At that time, our primary way of obtaining patients was by referral. And I didn't refer in my notes specifically to the referring physician. Let me look.

Q I had in my notes -- and I certainly want you to look for yours -- that it was Dr. Wallace McGahan. But if you would check and make sure that's what you understood.

A Yes. Yes.

Q So, Dr. McGahan sent him to you to treat what part of the body, was your understanding at that time?

A I don't know specifically. Typically, the request is worded "evaluate

and treat." Sometimes they'll put in specific area. But, at the time, the pain was primarily where he stipulated. Now, I do have here -- let's see. This is written on a prescription. Unfortunately, it's -- it says September the 5th, 11:30. So, I'm assuming that was the time of that appointment.

At the bottom, it says, "Diagnosis, spinal stenosis and carpal tunnel syndrome." Written on the bottom of that is "sciatica," "HNP," which is herniated nucleus pulposus, or a disc, "LS spine," lumbosacral spine. And this, I think, is Dr. McGahan's signature.

Q Is that on a note from Dr. McGahan's office?

A It's on a prescription sheet.

Q Okay. And that's Dr. McGahan's prescription pad?

A It is. It has his name at the top.

Q And is that note there part of your file?

A It is.

Q And is that the type of things that you have in your file that you keep in the

regular course of your business?
A It is.
Q And is the information contained on that note the type of information you receive from referring physicians that you review and use in your evaluation and treatment of the patient?
A Yes.
Q All right. And did you do so in this case?
A I did.
Q All right. So, basically, it appears as if he was sent here by Dr. McGahan for back problems, and you're evaluating him and treating him for what he reported to you to be back pain?
A Yes.
Q Okay. Now, the carpal tunnel was not part of his settlement, so we won't really deal with any of your treatment, if any, dealing with carpal tunnel.
A Okay.
Q We're specifically dealing with the back.
A Okay.

Q Would you go through -- I guess, after your history that he gave you in September, did you do an examination?
A I did.
Q And what did you do for the exam, and what were the results of the examination?
A A sort of general physical exam showed, for the most part, things were reasonably normal, as far as his heart and lungs and those sorts of things.
On neurological examination, there was some decreased sensation to light touch -- I didn't do pinprick at the time -- in a nonradicular pattern of the right leg compared to the left. "Nonradicular" meaning it didn't follow, necessarily, specifically, the pathway that a particular nerve root would follow on a normal -- what we call a dermatome chart.
Q Okay. What did you do after that exam?
A The first thing that I did was to initiate a trial of pain medication, Methadone 2.5, or two and a half milligrams, three times a day, a muscle relaxer,

Zanaflex, four milligrams, three times a day, and then, just set the patient to come back in a month for a follow-up visit.
Q All right. Do you have any other medical records from Dr. McGahan, or did the group send any, or did Mr. Sasser bring in any other medical records that dealt with this injury, for you to know how long he had been treating or what types of treatment he had had in the past?
A The only thing that I had from outside were some faxed records, which are difficult to read, because they transmitted poorly.
Q Who faxed those to you? Do you know?
A Again, the header, you can't really read, because it didn't transmit well. Now, I have another fax sheet here, but this was dated 3-1-02, so that doesn't have to do with the initial visit. Really, it's hard to read.
Q So, that fax note that's hard to read really wasn't part of your --
A It wasn't something that I relied

on to help me make my decision.
Q That's what I needed to know. All right. Now, I heard you state that you gave him Methadone. Now, for members of the jury who might not understand the use of Methadone other than for treatment of someone who's addicted to methamphetamines, would you explain that to them, please, why Methadone would be prescribed?
A Methadone is an excellent analgesic. Initially, it was developed for that purpose, not for rehabilitation. The advantage of Methadone in a chronic pain patient is twofold, really.
One is that, because of the way the body handles the medication, it stays in the body for a long time. So, it has the ability to have a prolonged relief.
The other thing is that, because of its chemical nature, it can treat certain special kinds of pain, particularly nerve-type pain. Not necessarily specifically for -- it's not used necessarily specifically for that type of pain. In other words, some patients get that medication even if they don't have a

nerve-generated pain.

But the basic reason for a medication like Methadone is, number one, it's effective. Number two, it can have a prolonged effect. And, number three, from an economic standpoint. It's very cost effective.

Q All right. Did you follow up with Mr. Sasser -- did he follow up with you, I should say, following that initial visit?

A He did. Now, at the time that Mr. Sasser was coming to the pain center, we typically would dictate notes. And I have some handwritten nurse's vital signs from several dates, October the 17th of 2000, January the 4th of 2001. But, unfortunately, I don't have dictated notes from those days. I can't tell you why. The next dictated note that I have is January the 30th of '01.

Now, let me just interject here, in another part of the record, we have a medication log. And for those dates that I mentioned --

Q Yes.

A -- I do have, in my log, that he

received, again, the medication, the Methadone. And it's reflected here that the dosage was upped from two and a half milligrams, three times a day, to five milligrams every eight hours, or three times a day.

Also, a change was made from Zanaflex to Baclofen, which is another muscle relaxer of a similar nature and of a comparable strength. That was dated 9-5, 2000 and 9-27, 2000.

Q Okay. Now, if I could, I want to show you what I've received. The defense attorney subpoenaed records from the Medical Center --

A Right.

Q -- and that covered yours. And as part of that, I've received a dictated note from 9-27. Does that appear to be --

A Yes.

Q -- your dictated notes?

A (Witness nodding head in affirmative.)

Q Were those kept separately than the chart you have here?

A Yes. This is sort of a tortuous system that we have. The hospital is the owner of the pain management center facility itself, and so, any records generated within the facility are official hospital records. And, as such, they become part of the patient's permanent hospital record.

However, because of policy, those physical charts can't leave the hospital building. And since our clinic building is physically separate, the only way for us to have access immediately to the patient's record, without having to send someone across to the hospital, is to have our own -- what we call convenience record, which has everything that we generate out of the pain center.

And, actually, there are some things in this convenience record that may not be up to this point in the hospital record, such as lawyer letters, insurance company letters, things that don't necessarily have to do with official hospital business, that really are only unique to our pain practice.

Our current practice, now, is that we

basically scan everything into the patient's record. But, in essence, this is only for our convenience, and it's not the official record.

Q But it is a record kept here in your office --

A Yes.

Q -- in the normal course of your business?

A Yes. And, normally, we should have these. As I said, I can't explain why they aren't in here.

Q All right. I would like to have that stack of documents from 9-27, 2000, admitted as Plaintiff's Exhibit No. 2, so we will have them attached to your deposition. But, if you would, could you review them now and --

A Sure.

Q -- let's talk about that visit? Now, I'm going to -- for the sake of brevity and for the sake of the jury's understanding, I would prefer not to necessarily go through visit by visit, unless you need to.

A No, I don't.

Q Once we get past the first few visits, if you could just explain your general course of treatment --
A Sure.
Q -- and how he fared with you, that would be more natural in the way we talk about things.
A Let me just take a look at this real quick.
Q Sure.
A In essence, I followed Mr. Sasser on an average of every three months, with an occasional visit in between those. The main modalities during that time were medication management, with an occasional trigger point injection for some complaints of muscle spasms in the legs.
Q Okay. Can you explain the trigger point injections to the jury?
A Certainly. A trigger point injection is an injection into the muscle with a small amount of, in our case, local anesthetic and anti-inflammatory steroid medication, the purpose of which is to quiet down an inflammatory process in the muscle

which can lead to localized pain.
Q The pain that you saw him exhibit and the muscle spasms and things of that nature that you document, are they consistent with the original diagnosis that was sent from Dr. McGahan of the lower back pain, the spinal stenosis, and things of that nature?
A Yes. But, in some cases of people who have a back problem, because the pain may alter their gait, that may pose more of a strain on certain muscles, which cause the muscle pain.
Q Okay. So, the muscle spasms are a result of an altered gait?
MR. KNOTT: Object to the form.
A They can be.
Q In his situation, did you have an opinion as to what was causing the muscle spasms that required the trigger point injections?
A Not really, other than what I just said.
Q Was there anything that was unusual about that presentation to you --
A No.

Q -- or that gave you concern?
A (Witness shaking head in negative.)
Q Okay. Now, I would want you to assume, hypothetically, because you don't have the records in your chart, that, on September the 13th, 2000, which was a few days after your first visit with Mr. Sasser, that Dr. McGahan, who was his workers' comp-approved treating physician, has a note in his chart indicating the diagnosis for Mr. Sasser was low back pain, muscle spasms, CAD, and spinal stenosis. Is that also your understanding of his diagnosis when you were treating him?
A Well, the CAD, the typical meaning for that is coronary artery disease, which --
Q Has nothing to do with his back? Is that pretty much correct?
A That's right.
Q But the lower back pain, muscle spasms and spinal stenosis is consistent with your treatment?
A Yes.
Q Now, you treated him from September of 2000 until when?

A The last note that I have is dated 5-20-04, May 20th of '04.
Q Okay. And in between September of 2000 and May 20th of '04, were you treating him for the same thing, the lower back pain, the spinal stenosis, and the muscle spasms?
A Yes.
Q Was there anything during that time that changed about his condition, where you were treating him for something other than what he was originally referred by Dr. McGahan for?
A No.
Q Okay. And your treatment, I believe you said, was basically --
A Medication.
Q -- medication and occasional trigger point injections?
A Yes. That's correct.
Q In your opinion, was the medication and the occasional trigger point injections necessary to treat the chronic back pain that he was sent here by Dr. McGahan for?
A Yes.
Q In your opinion, were those

21

medications directly related to the back injury that he had suffered?
MR. KNOTT: Object to the form.
Object to the leading.
A Yes.
Q The judge in this case, back in Barbour County, basically had asked that Dr. McGahan review all the medicals and determine whether there was an injury on the job, and report to him.
And Dr. McGahan submitted a letter to the judge that basically said, "Mr. Sasser, in my medical opinion, received a work-related injury on or about September the 8th, 1995. I reached this opinion after several office visits and examinations.
I do not believe Mr. Sasser has anything to gain from a neurological examination at this time, although I will be happy to schedule him a visit or visits.
In my opinion, Mr. Sasser's approximate medical expenses should be $10,000.00 per year. I could elaborate on the nature of his injury, if necessary. So, if more information is needed, please let me know."

22

And that was dated January the 3rd of 2000. Do you have any information at all, either from Mr. Sasser's presentation, from any other source, from your own observations, examinations of him or anything, that lead you to believe Dr. McGahan was incorrect when he stated that he had received an on-the-job back injury in 1995?
MR. KNOTT: Object to the form and the predicate. Based on hearsay.
A Well, from my standpoint --
Q Yes.
A First of all, I didn't have access to that information. But, second of all, you know, when a patient presents to us or any physician and states the reason for their visit, we have to believe what they say is true.
And when Mr. Sasser came in, he said that the reason he had his back pain was because he was involved in a work-related accident, lifting a large motor at the General Electric plant.
Q Sure.

23

A So, as far as I was concerned, that was the reason that he had his back problem.
Q And before he came to you -- again, you may or may not be aware of this. Before he came to you, there had been a settlement and a finding of fact and an order.
And, specifically, there was one, I believe, in 1998. And then, again, in 2000, the judge specifically found that the plaintiff sustained a back injury as a result of an accident which occurred on or about September the 8th, 1995, which arose out of and in the course of plaintiff's employment.
And then, the judge issues an order stating that the defendant shall continue to be responsible for future medical expenses as provided in paragraph three, which is future medical expenses related to that injury.
Assume, hypothetically, for me, now that you know Dr. McGahan's opinion that it was work related, the judge has issued an order that it was work related, and that that work-related injury was to his lower back. And you now know Dr. McGahan's diagnosis at the time he sent him to you.

24

In your opinion, is the condition you were treating him for the same condition that it appears Dr. McGahan had been treating him for and that the judge issued an order regarding?
MR. KNOTT: Object to the form.
Object to the hypothetical and the predicate. Object to the leading.
Q Assuming those facts are true. Assuming what I read to you was --
MR. KNOTT: Same objection.
A Well, all I know is that -- yes, I assume that they were the same. But, again, when Mr. Sasser came in, he told me that his back hurt --
Q Sure.
A -- that he got hurt on the job. And that's what I knew.
Q Sure. Now, during the course of your treatment of him, did you have him -- when he's taking his medication, are these scheduled medications, meaning they have to be regulated in the disbursement of them?
A Yes.

Q And did you, as part of your normal practice, monitor a patient's medication and medication level to see that they're not taking too much medication and things of that nature?

A I did.

Q Okay. Was there anything in Mr. Sasser's chart or anything that you observed in him through testing or through your observations directly that made you feel that he was exaggerating or malingering in his symptoms in any way?

A Well, the purpose of our monitoring of medication, and, in our case, the use of urine drug screens, really is only a purely objective test to determine the presence or absence and the levels of certain medication. Really doesn't address or even look into the reasons for the medications or the incentives or disincentives of a particular patient.

I understand your question. As I understand your question, was I using the testing to determine whether he was legitimate. That's not the reason. The reason is to determine, just like you --

Q If he was taking it or he was taking too much of something else?

A Just like you check a person's blood sugar to monitor whether they are getting enough diabetic medication.

Q Before you prescribe medication such as Methadone and Oxycontin and other medications for a patient, do you make an independent determination that, in your opinion, they need that medication for their medical condition?

A Yes.

Q And that they have a legitimate medical need for it --

A Yes.

Q -- rather than just someone who's addicted, and comes to a doctor, pain seeking -- I mean, medication seeking?

A Yes. Well, we make an effort to do that.

Q Is that a concern of yours to make sure patients aren't coming here --

A Just to get medication?

Q -- just to get medication, just to get these controlled substances?

A Yes. Oh, it's a great concern of ours.

Q Was there anything about Mr. Sasser's presentation or history or information you learned during his case that made you think he was here simply for the purpose of seeking controlled substances?

A No.

Q Okay. Now, you saw him last in May of '04?

A Yes.

Q Do you have anything in your record to indicate why his treatment stopped?

A He just didn't come back.

Q Okay. Do you have knowledge as to whether the workers' compensation carrier, or the company who was paying for his medicals, decided to no longer pay for that treatment?

A I have no knowledge of that.

Q I have a letter dated July 12th of 2004, that was sent from Intracorp, allegedly addressed to you.

A And I allegedly have it in my chart.

Q And you do have that note in your

file?

A I do.

Q If we could go over it. It basically is a letter denying your request for office visit for medication management. They state -- the rationale in the letter is stated as, "The claimant has low back pain. It is" -- no. Your rationale, I'm assuming. "... low back pain. It is worse with riding long periods of time. TPIs" -- I'm not sure what TPI is. Do you know what that means?

A Trigger point in injections.

Q Okay. -- "were given 1-20-04 and 5-20-04. He is taking Oxycontin and Valium. There is insufficient recent objective documentation of the claimant's response to the TPIs of 5-20-04 to determine if medications are still needed in support of the request. There is insufficient documentation of failed conservative treatment to support the necessity of the request, such as daily compliance with the home exercise program."

So, basically, this is their rationale, apparently, for denying your request for a

preapproval of this treatment.
A Uh-huh.
Q And the treatment you were asking for was another trigger point injection or just continued pain management? Do you know?
A I would assume that, from the wording in the letter.
Q Okay. In your opinion, was the treatment you were requesting from -- for your office visit that you requested of them, in your opinion, was that necessary --
MR. KNOTT: Object to the form.
Q -- for his ongoing pain management related to his back problems?
MR. KNOTT: Object to the hypothetical.
Q I'm going to go on the record right now. I mean, I'm asking you -- I'm not hypothetically asking you anything. I'm asking you, in your opinion -- am I correct that your office requested, I guess through the normal channels, a preauthorization for treatment for Mr. Sasser through workers' comp? Is that correct?
MR. KNOTT: Object to the form and

foundation.
A I would assume so.
Q And if you did that, would you be asking for preapproval of something you thought was medically necessary for him?
MR. KNOTT: Object to the form and foundation.
A Yes.
Q In your opinion, was the treatment that you requested that they pay for here, that they denied, a necessary treatment for his pain management for his back injury?
MR. KNOTT: Object to form, foundation and leading.
A Yes.
Q Okay. Do you agree with their rationale for having denied that? That they didn't think there was sufficient objective documentation of his response to the trigger point injection?
MR. KNOTT: Object to the form.
Q Do you agree with that rationale?
MR. KNOTT: Object to the form.
A Well, since I don't know what their guidelines are, going into it, for sufficient

objective documentation, it would be hard for me to say whether I agree with it or not.
Q Was there sufficient information for you to ask for that continued treatment?
A Yes.
Q Okay. And as his treating physician, in your opinion, would that be your decision to make, whether he needs medical treatment? Regardless of whether they're going to pay for it or not, is it your decision, in your opinion, to decide what he needs medically?
MR. KNOTT: Object to form and foundation.
A Yes.
Q When you last saw him, in May of '04, was it your understanding and your -- I guess this. Did you have an opinion or an expectation that Mr. Sasser was continuing to treat with you as he had done for the last four years? That he would continue to treat with you?
A Yes. As a matter of fact, I've got a little handwritten addendum on the note dated -- well, not dated, but on that day,

that says, "Follow-up already set." So, apparently, having asked for Mr. Sasser to come back another time, the secretary had put that appointment on our books.
Q And is that the normal course for your office, that, when they're here, and they're going to do a follow-up, your secretary goes ahead and schedules the next appointment?
A Yes.
Q Okay. Was there anything that had changed about Mr. Sasser's condition from 2000 to the May 2004 that made it no longer necessary for him to need this treatment for his back pain?
A Not that I could tell.
Q Did he suddenly get better to the point that he would not need to come in for pain management?
A Not that I could tell.
Q At the time that they denied him continued treatment, can you tell the jury what medication he was taking, what prescriptions you had given for him?
A Well, I can tell you, on that

particular date, based on our log. The last prescriptions that I have logged in are actually 6-18-04, and, just prior to that, 5-18-04. The medication was Oxycontin, 40 milligrams, one every eight hours.

He had also, prior to that, in December, December the 29th of '03, had been issued a prescription for a medicine, Topamax, which we use sometimes as an adjutant medication, or an additional medication for certain types of pain, one to two at bedtime. 62 pills prescribed with as-needed refill. So, that meaning he wouldn't have needed another prescription for another year.

Q Now, the Oxycontin, how long had he been taking Oxycontin prescribed through your office?

A First prescription for that was January the 30th of '01.

Q Was that something he took, then, consistently, or at least was prescribed consistently from '01 until '04?

A Yes.

Q If you decide to take a patient off of Oxycontin, do you have any prescribed

protocols you follow in -- especially someone who has been on the medication for over three years, for taking them off of that medication?

A Usually, if someone is going to voluntarily come off of a medication -- and not just with opioids, but typically other medications, as well, we'll use a weaning protocol. There's no specific percentage or milligram dosage. It just depends on what the patient is taking.

But, typically, every three to five to sometimes seven days, the dose will be decreased by a little bit, until such time as the medication is completely discontinued.

Q And why do you do a weaning process with those medications, in particular, Oxycontin?

A Well, particularly with the opioids -- not just Oxycontin, but with all of the opioids -- one of the things that we're concerned about in patients who are using these sorts of medications long term, they can develop physical dependence. And if the medication is stopped suddenly, they can go

through withdrawal or experience what's called an abstinance -- acute abstinance syndrome.

Q And can you describe what that withdrawal or abstinence syndrome typically -- how it presents?

A Well, it usually presents as agitation and anxiety, cold sweats, GI cramping, diarrhea, sometimes headache, sometimes difficulty sleeping. Typically, these things start about -- anywhere from three to five days after the medication is stopped, and they usually last for three to five days.

Q In Mr. Sasser's situation, when the workers' comp company -- or when the defendant in this case, Ryder, no longer approved your treatment, they no longer approved medication prescription refills, as well.

Would you expect Mr. Sasser, having been on Oxycontin for more than three years, if he was simply cut off, without weaning him, would you expect he would experience the withdrawals that you've talked about?

MR. KNOTT: Object to the form and predicate. Improper hypothetical.

A It's not consistent. In other words, it doesn't happen to everybody. I've seen people who are on much larger doses of medication stop suddenly, for whatever reason, and not have any problem with that. I've seen people who are on much smaller doses have what we call microwithdrawal between doses of medication that they continue to be on.

So, in essence, the answer is, I wouldn't expect it, but I wouldn't be surprised. I neither expect it nor unexpect it, if you will.

Q Okay. He answered some interrogatories that the defendant asked him over a year ago, certainly before he sat in here today and heard your testimony, and stated that he laid in a hospital bed at home in cold sweats, unable to eat, taking bottles of nitro tablets, vomiting, diarrhea, cramps, thinking I was dying. And that's his description of when he suddenly stopped

taking the Oxycontin, because Ryder cut him off.

Does that sound consistent with what you would expect, if someone, in fact, went through that type of withdrawal? That description of it?

A Yes.

Q Okay. Is that a pleasant experience, based on what you've seen?

A I've never been through it.

Q Have you had patients describe it to you?

A I would assume that it is. I have had it described as unpleasant. But, having no personal experience, I can't say that it is or not.

Q But, as a physician, you do your best to stop that from happening for a patient?

A Certainly.

Q Okay. Because it's not something that you, as a physician, would like to see your patients go through?

A Exactly.

Q Okay. Now, I'm going to ask you

some questions. Ryder sent medical records to some other doctors -- they call them peer reviews -- and asked them about some things, including your treatment of Mr. Sasser.

One of them, specifically, was Terrance Wilson, who is board certified in physical medicine and rehabilitation, with a subspecialty certification in pain management -- or pain medicine. Is that the same board certification you have?

A I don't know.

Q Your board certification is in anesthesiology? Is that correct?

A Well, your question is a little more complicated than you think.

Q Okay. Maybe you can explain it to me.

A First of all, physical medicine and rehab is an entirely different specialty from anesthesiology. Basically -- well, it's a specialty also known as physiatry. So, they do physical modality, physical therapy, occupational therapy. They're physicians. They're not just physical therapists. They're physicians. But, what his specialty

focus in pain medicine and pain management is, I couldn't say, because I don't know anything about their board process. And I don't know when he received that extra certification, which makes a difference, because there may or may not have been a formal process, and certification may be a -- having gone through a truncated process or it may be a formal process. That entitlement doesn't tell me the nature of his extra training.

Q Okay. So, you are board certified in anesthesiology?

A Yes.

Q And you have a subspecialty through the anesthesiology board for pain management, or is it pain medicine?

A Well, it depends on who you go to. My boards in pain medicine are through the American Academy of Pain Medicine, not through the American Society of Anesthesiology.

Q Okay. If you are a member of the American Academy of Pain Medicine, does that mean you're automatically certified through

them?

A No. You have to take an examination.

Q So, the membership is just something you can do without being board certified?

A Right.

Q Okay. So, the fact that this Doctor is a member of the American Academy of Pain Medicine doesn't give us any more information regarding his certification in pain medicine or not? Is that correct?

A That's correct, although -- not to say that he didn't take the examination --

Q Sure.

A -- and pass it.

Q It doesn't help us one way or another?

A No.

Q Is that fair?

A I mean, I'm a member of lots of societies, which typically don't provide certification, so --

Q All right. He specifically states that he reviewed -- it says available medical

records. I'm not quite sure what was available. But, initial record review performed by this evaluator recorded in the report of 3-17 of '03. Additional documentation has been submitted for review. Medical treatment provided during 2004 included bilateral trigger point injections into the vastus lateralis muscles, performed on 1-20 of '04. During the calendar year 2003, there was documentation of medical encounters on 4-9 of '03, 5-7 of '03, 6-24 of '03, 7-18 of '03, 10-28-03, 12-29-03. Trigger point injections were performed into the left peroneus longus muscle on 10-28-03 and 12-29-03. Is that your treatment?

A Yes.

Q Okay. So, he's basically saying he has reviewed your treatment records?

MR. KNOTT: Object to the form.

A Right.

Q Is that correct?

MR. KNOTT: Object to the form.

Q At least based on what he states here, those dates would correlate with your treatment?

A Those dates correlate with my treatment.

Q And the trigger point injections were things performed by you here in your office --

A Yes.

Q -- or at the clinic?

A Except -- I'll just take issue with the 12-29. That was a follow-up visit. My records don't reflect trigger point injections being done at that time. That's nitpicking, but --

Q Well, no. I mean, he's basing his opinion on saying that those trigger point injections were performed on those he listed in this record. You're taking issue that you did not do a trigger point injection on 12-29-03?

A Right, but -- yes.

Q Now, he states, "Based on his review of the available records, it is my professional medical opinion that none of the treatment documented during 2003 and 2004 is causally related to the work injury of 9-8 of '95."

Now, in your opinion, was the treatment you provided to him, as documented in those treatment records, a necessary treatment to treat the back injury he came in here from Dr. McGahan for?

MR. KNOTT: Object to the form and hypothetical.

A Yes.

Q Do you disagree, then, with his assessment -- if, in fact, the injury on 9-8 of '95 was the low back injury that Dr. McGahan was treating him for, do you disagree with that assessment and that opinion of this man?

MR. KNOTT: Object to the form and predicate and hypothetical.

A Yes.

Q As a physician, do you prefer to see a patient and actually examine that patient and follow that patient in order to offer an opinion about that patient's condition, versus reading records from other doctors?

A Yes.

Q Which one, in your opinion, as a

physician, is more helpful to making an accurate assessment of a patient?

A Direct contact with the patient.

Q Okay. And you had had direct contact with this patient from September of 2000 all the way through May of 2004?

A Yes.

Q Okay. I have another opinion they submitted from William Cabot, a diplomate of American Board of Orthopedic Surgery, fellow of the American Academy of Disability Evaluating Physicians. And it says, apparently, he's president of that. That physician, is he board certified, based on this record, in any area that you're board certified in?

A No.

Q In his opinion, he thought that Mr. Sasser needed epidural blocks --

MR. KNOTT: Excuse me, Amy. What date record are you looking at?

MS. SHUMATE: I'm looking at the letter that you attached to your summary judgment motion dated May 15th, 2002.

MR. KNOTT: Is that something in his file or is it --
MS. SHUMATE: No. It's something outside -- it's what you presented to the court. I'm just going to ask him questions about it.
MR. KNOTT: Well, I know you and Bill have had some communications about the deposition. Bill had raised some concerns about expert designation.
MS. SHUMATE: Sure.
MR. KNOTT: And you had indicated that you were just taking his deposition as a treating physician.
MS. SHUMATE: I am.
MR. KNOTT: So, I think the scope of this deposition should be based on his treatment and his opinions concerning --
MS. SHUMATE: And I agree.
MR. KNOTT: -- his treatment and

the conditions. And I think if we go outside of that and start having him comment on other opinions of other people that were not involved in Dr. Marsella's course of treatment and with his discussions with other -- or communications with other physicians about the conditions, then I think we're kind of going outside his role as a treating physician, and I think we would be putting Dr. Marsella more in the place of being a regular sort of court expert as opposed to a treating physician. And so, I think we need to -- so, we're going to object --
MS. SHUMATE: Okay.
MR. KNOTT: -- to the extent that this line of questioning is going beyond his regular role as a treating physician, and

he's not been designated for that purpose.
MS. SHUMATE: Okay. And your objection is noted on the record, and I appreciate it. I am certainly going to ask him questions, if there's another physician who has disagreed with his treatment regimen, whether he feels his treatment regimen was, in fact, necessary. And I'm going to ask him that, and he can answer those regarding a treating physician, without being hired as an expert. So, your objection is on the record.
Q Now, this Dr. Cabot, when he gets to the discussion of your treatment, basically he felt the nondermatomal numbness that you mentioned, the nondermatomal pattern, was significant, because -- I guess, to him, that would be significant.
Did you find anything about that particular note you entered on 9-5, about him

having nondermatomal pain or numbness, that made you feel like he was not being truthful or honest with you?
MR. KNOTT: Object to the form and the predicate.
A No.
Q Do you believe anti-inflammatory medication, rather than the narcotic medication you were providing to Mr. Sasser, would have been appropriate in this case?
A Are you asking instead of or in addition to?
Q No. Instead of. Do you think that would have helped him, given what you saw him with for four years?
A I think it would have been inadequate.
Q Inadequate. And is that based on your observation of the way he did respond to narcotic medication from September of 2000 to May of 2004?
A Yes.
Q Do you believe an epidural block would have been more helpful than the treatment you gave him for the treatment of

his spinal stenosis?
MR. KNOTT: Object to the form and the predicate.
A I have a little hand comment, handwritten comment, on the follow-up visit note of 1-20-03, in which I have said, the patient had five to six LES, or lumbar epidural steroid injections, without benefit. That being the case, on that date, from 1-20-03, from that point onward, I would have seen little benefit to do more of those.
Q Okay. He also makes the statement that narcotics for degenerative disc disease typically take a patient down a road which does not have a good outcome. Would you make that assessment in Mr. Sasser's case? Would you agree with that statement in Mr. Sasser's particular case?
A Well, since I don't know what that statement means, I can't say.
Q In your opinion, for your treatment for Mr. Sasser, based on your hands-on exams and evaluations of him throughout that four-year period of time, did you believe that the medication and trigger point

injections were the best, most conservative treatment for his pain?
MR. KNOTT: Object to the form.
A Yes.
Q And were those treatments of the medication and the trigger point injections, in your opinion, a medical necessity to treat the pain he suffered in his lower back?
MR. KNOTT: Object to the form and the predicate.
A Well, again, you know, I understand the legal point of medical necessity. There aren't very many things in life that are necessary. It's certainly medically appropriate. I don't like that "medically necessary" term, personally.
Q Sure. You understand, legally, that is the term --
A I think it was appropriate treatment for his problem. In that sense, medically necessary, if that's how that term is used.
Q And without that medication and trigger point injections, and, thus, with no other treatment, would you expect that his

pain would be significantly worse than what you had got it regulated to?
MR. KNOTT: Object to the form and the predicate.
A Well, I couldn't say. All I can say is that, with the medication and the treatments that I provided, Mr. Sasser wasn't cured, wasn't 100 percent better, was not pain free, but seemed to me to be at least able to function and maintain some -- have some quality of life that he may not have been able to enjoy without the medication and treatments.
Q Did he have a higher level of functioning, physical functioning, while he was taking the medication and having the injections, meaning he could do more things, he could be more active, because pain wasn't as limiting?
MR. KNOTT: Object to the form and the predicate.
A I don't have any objective information in that regard.
Q Would that be what you would anticipate in his condition?

A You know, typically, pain scores, which we sometimes relate and sometimes don't, were on a scale of ten. Zero, no pain. Ten, great pain. His typical pain scores were five, six, seven, in sort of the middle range. So, in our patient population, that usually implies reasonable pain relief.
Q And I'm going to ask you this based on your experience with Mr. Sasser and with other patients who have similar-type conditions.
If he was not able to take the medication because the company either wouldn't pay for it or he had no financial resources, whatever, and he was suddenly taken off that medication and no longer allowed to have medical treatment, including any pain management at all, would you anticipate that, based on your four years with him, that his pain complaints would go up?
MR. KNOTT: Object to the form and the predicate.
A Yes. I would expect that, yes.
Q You would expect that. That would

be something that, based on your treatment of him, you would expect that to happen to him, if he were not able to have pain management?

MR. KNOTT: Object to the form and the predicate.

A Yes.

Q Is that correct?

MR. KNOTT: Object.

A That's correct.

Q I mean, the whole point of your job for him is to help reduce his pain? Correct?

MR. KNOTT: Object to the leading.

A Part, yes. One of the things. I mean --

Q What else would it be?

A Well, typically, we reduce pain, reduce the subjective symptoms of pain, improve quality of life, and improve function.

Q Okay. The medication that he was taking, the Oxycontin and things like that, do they have side effects that would affect him when he's taking them?

A They have side effects that could affect anybody.

Q Such as?

A Well, the typical ones are itching, nausea, vomiting, constipation, urinary retention. At higher doses, respiratory depression or arrest. Typically, that's at toxic doses. Those are sort of the -- well, sedation, confusion, mental status changes.

Q Okay. Is that something -- someone who, certainly, like Mr. Sasser, who had been taking this medication for years, is that the type of confusion, sedation -- does that mean sleepiness, things of that nature --

A Yes.

Q -- that he would experience?

A Possibly.

Q The level of pain he was subjectively reporting to you, as well as the medication regimen he was on, would that interfere with his ability to hold down a 40-hour-a-week job, in your opinion?

A I can't say.

Q Do you find a lot of your patients who come in with his level of pain and the four years of pain management to be -- a lot of them are in the disabled category,

workwise?

MR. KNOTT: Object to the form and the predicate.

A I can't say that.

Q Okay. Was there anything about him that made you feel like he was faking? I mean, no better word a jury will understand than the word "faking." Is there anything in his presentation to you or in his tests that made you feel like the man was faking his problems?

A No.

Q Would it be fair to say you would not have continued him on this narcotic regimen had you felt that?

A That's correct.

Q As his treating physician as of May of '04, do you have an opinion as to whether, at that time, he should have continued with pain management?

A My opinion is that he should have.

Q Okay. And would that be to a reasonable degree of medical certainty that that pain management treatment would have continued to be necessary for his back pain?

A Yes.

Q Now, did you have any discussions, or did, to your knowledge, your office have any discussions with Ryder or Intracorp regarding their cutting him off?

A Not that I know of.

Q Were you told about appeal processes or that you, as a physician, were supposed do something to get him reinstated or anything along that line?

A Well, the only -- you referred earlier to a communication of 7-12-04.

Q Yes.

A In my record here in front of me, that is the only communication that I received.

Q And was that indicating to you that they weren't going to ever let him come back, or just they weren't going to approve that particular request for treatment?

A You know, I really don't know the answer to that question. It only says that -- they refer to specific dates of treatment. And it just sort of generically says that I can receive -- the treating physician may

receive a copy of the guidelines used in the review. If I have additional clinical information, et cetera, et cetera, that I have the capability of appealing, and tells me to whom to appeal.

Q And did you follow up with any appeal or send any additional records to them, to your knowledge?

A Not to my knowledge.

Q Did you send any further requests for treatment for Mr. Sasser to Intracorp that were denied?

A Not to my knowledge.

Q Did you send any further requests, whether they were denied or not?

A I don't think so.

Q Okay. Do you have any independent recollection, outside of what's in your chart, that deals with this issue of them having cut him off?

A About what?

Q About whether Intracorp was going to continue to pay for him or anything.

A I have no idea.

Q If, in fact, Ryder -- I have a

letter dated June 17th, 2004, that the defendant submitted for his summary -- excuse me -- that I had in my file from Ryder -- or Intracorp. Excuse me. No. It's from Ryder -- that says, to Dr. McGahan, to Dr. Marsella, to Clio Pharmacy. "As the adjustor for this workers' compensation case, I am currently notifying you that, effective immediately, any and all medical services, procedures and prescriptions provided to this patient must go through the workers' compensation precertification process." Did you receive that letter from Marty Lloyd?

A Well --

Q Would that be something you would keep in this chart versus the Medical Center chart?

A That would be something that I would have in this chart, and I don't have it here.

Q Okay. And if it states that no further action or precertification was ever requested, therefore, Mr. Sasser's med treatment/coverage under workers' comp was denied effective 6-17-04, were you given any

information from Intracorp or Ryder that that was the case? That he had been cut off totally?

MR. KNOTT: Object to the form and the predicate.

A I don't have that letter in my chart here.

Q To your knowledge, did you receive any information from them as to the need for precertifications?

A Typically, that doesn't come to me.

Q If, in fact, you had received that, would you have done the procedures necessary, to your knowledge, or your office staff would have done the procedures necessary to see that Mr. Sasser continued to get his treatment?

A Typically, yes.

Q And based on what I've talked to you about Dr. Cabot and Dr. Wilson's opinions regarding your treatment, do you disagree with their opinions regarding your treatment?

MR. KNOTT: Object to the form and the predicate.

A Well, I never really heard Dr.

Cabot's opinion. I'm sorry. I think we got --

Q We went off on some of the treatments. He would have said the opinion regarding needing anti-inflammatories --

A Oh, yes.

Q -- the need for epidurals, and the need that narcotic medication is not necessarily a good outcome. Those opinions. Do you disagree with those two doctors' assessments of this particular man's case?

MR. KNOTT: I'll object to the form and the predicate. And I'll point out that Dr. Marsella has, I believe, not even reviewed the whole --

MS. SHUMATE: I understand.

MR. KNOTT: -- written opinion of Dr. Cabot, and that what he's being asked to comment on now are the pieces of the letter that have been quoted or summarized by plaintiff's counsel.

MS. SHUMATE: I'm sorry. Did we

have usual stipulations on this deposition, that all other objections besides form of the question will be reserved for trial?

COURT REPORTER: None were stated.

MS. SHUMATE: Do we have usual stipulations, or do we need to go back over this?

MR. KNOTT: We have the usual stipulations.

MS. SHUMATE: Thank you.

Q You can answer the question, despite his objection.

A Well, I think we already addressed the first -- not Dr. Cabot, but the other opinion. As far as Dr. Cabot's opinion, I guess we did discuss that.

No, I don't think nonsteroidal anti-inflammatories by themselves would have been adequate.

No, I don't think that epidurals would have been appropriate, because, as I mentioned earlier, back in January of -- whenever it was. 1-20-04, I think it was. I

think that was the date -- that Mr. Sasser told me -- yeah. 1-20-03. I'm sorry -- Mr. Sasser had said he had had five or six epidurals without benefit. And I didn't see any point in continuing with that.

The third thing about the -- I don't want to say he's saying probable, but possible poor outcome with the continued opioid use is true in anybody's case.

In Mr. Sasser's case, he was complying on his medication regimen, as evidenced by the fact that he never, in my opinion, requested overages of his medication or early refills, and by urine drug screen, was always compliant and within the parameters for the use of those medications that I prescribed for him.

Q And would those drug screens have shown if he were overmedicating?

A Yes.

Q And that was not a concern throughout all those urine tests that your office performed?

A That's correct.

Q Okay. The use of those particular

medications he was on, would they give someone the slurred speech at times, or seem drowsy and things of that nature, to someone who maybe doesn't know what they're taking?

A Theoretically?

Q Uh-huh.

A Yes.

Q Okay. So, if there were times when someone might notice if he had slurred speech or seemed drowsy or sleepy, that would not give you great concern, given you knew he was compliant with his medication? Is that fair to say?

A There are a lot of reasons for people to slur their speech and be sleepy. If you stay up for three days in a row, it will do that to you. So, I wouldn't say that slurred speech and sedation, sleepiness, are necessarily indicative of overuse of anything, any substance.

Q And you specifically tested him regularly and routinely, through the urine drug screens, to make sure there was no overmedicating going on? Is that correct?

A That was the intent.

Q And that's what you do for your patients who take narcotics like this, to make sure they're not overmedicating themselves -- is that correct? -- or getting medication from sources other than what you give them?

A In general terms, we use the screens to determine compliance.

Q That they're taking it, and they're not selling it somewhere, and that they're not taking too much?

A Right. And that what is being prescribed is what's being taken, and what is being found has been prescribed.

Q If he had been determined by -- hold on a second. I'm sorry.

MS. SHUMATE: I'll tell you what. I'll probably save that for rebuttal, because I'm sure something will come up about it. So, that will be all the questions I have.

I would ask that your convenience chart that you've testified from today be copied

and attached in its entirety as Plaintiff's Exhibit No. 3. That way, we'll have a clear picture of what you had versus what the Medical Center had, if that's all right.

DR. MARSELLA: Fine with me.

MS. SHUMATE: All right. And that's all the questions I have. If you would certainly answer Mr. Knott's.

EXAMINATION

BY MR. KNOTT:

Q Hi, Dr. Marsella. My name is Conley Knott, and I represent Ryder in this case. And I have a few questions to ask you about the course of your treatment and some of your opinions.

Amy has already covered a lot of the course of treatment, so, hopefully, we'll be biting off smaller and smaller chunks as we go, as we put a finer point on things. And also, for that reason, I might seem like I'm

jumping around a bit, because there's no point in starting at the very beginning, chronologically.

But, that being said, I do kind of want to start at the beginning of your treatment in 2000, and ask you -- and it was the year 2000 that you first saw him, or was it 2002?

A No. It was 2000. September the 5th of 2000 was my initial visit date.

Q And there was some discussion about the information that you, as a treating physician, have had with regard to the original causative event that might have led to the conditions and the complaints that Mr. Sasser came here for, specifically, just for the layperson's parlance, what it was that made him have the back pain, what happened to him.

Is it your testimony that you have been relying on the patient's own reports of what happened to him to cause his pain?

A That's true.

MS. SHUMATE: Object to the form of the question.

Q Is the patient's verbal report to

you about what happened to him to cause his pain, is that the only thing that you, as a treating physician, have relied on in terms of your opinions concerning what caused him to have the pain?

A Yes.

Q Now, I want to ask you a little bit about one of the terms in your office notes that you testified to a little while ago, a nonradicular pattern. A nonradicular pattern is what you found with Mr. Sasser? Is that right?

A Yes.

Q You explained something about how that relates to a nerve root. Could you explain that?

A Certainly. There are nerve roots that come off of the spinal cord. Imagine, if you will, a large taproot, underground, and off of that come smaller roots. Well, the large taproot would be comparable to the spinal cord, which comes off of the brain.

Smaller nerves come off of that, which we call the nerve roots. And each of those -- there's one on each side of the body at

various levels, from the top of the spine all the way down to the bottom of the spine. These nerve roots exit the spine, and then, go to parts of the body, depending on where they come off. Each of those nerve roots then gives off smaller nerves, which give off smaller nerves, eventually going to the end of the line.

Typically, each nerve root serves a certain part of the body, and historically have been mapped out in what have been called dermatomes. Now, obviously, everybody is different. And so, a dermatome in one person for a particular nerve root would be different, to an extent, than another person. But, in general, we rely on these maps to give us an idea about what nerve root may be involved.

Sometimes there's crossover between dermatomes, as you get further out, so that, sometimes, the picture is not quite as distinct. And so, a nonradicular -- the term "nonradicular" is only meant to imply that it doesn't strictly follow the course of a dermatome or a nerve root map, if you will.

69

Q Okay. Now, in a patient where the complaints of pain do follow that roadmap, is that what you would call a radicular pattern?
A Right, if it's consistent with what we know as the dermatomes.
Q And when you find a radicular pattern in a patient, are you able to conclusively relate that complaints of pain to some sort of condition with the spine?
A In many cases, yes.
Q When there's a nonradicular pain, when the complaints of pain don't follow that classic roadmap, is there less certainty to where in the body the pain is originating?
A Yes.
Q And so, it's not necessarily, in those cases, related to a back problem specifically? It could be a number of other things?
A Well, if we think back about the fact that, you know, the body is a very complicated machine, the nerves aren't the same in everybody. And so, while there may be problems in the back causing problems with more than one nerve root, as you get further

70

out towards the end of the line, the distinction becomes blurry -- may become blurry. Whether it will or not, no one can say. But it may become blurry to the point that it's difficult to say exactly where the pain is originating.
But, in general terms, if there is, in this case, lower extremity pain, well, the lower extremities, the legs, receive their innervation from the lower part of the spine, in the lumbar area.
Now, the nerves come off of the spinal cord higher up, but they exit the spine in the lumbar area, so that if there's a problem in the lumbar spine causing an issue with a nerve root as it exits the spine, while it may be difficult to say specifically which nerve roots are involved, in general terms, you can say that leg pain may certainly be related to back pain, and would more particularly be related to low back pain -- a low back problem. Not pain, but problem.
Q When we get to that point where -- in terms of attempting to isolate nerves in the back and the branches off the spine as

71

maybe being related, maybe not, to complaints of leg pain, are there tests, like, radiology tests, that a doctor can use to determine that?
A There are several things. Certainly MRIs, magnetic resonance imaging scans, can be used to see if there is a presence or absence of a herniated disc or a bone spur or anything like that.
There are tests that can be done to check the integrity of the nerves and the muscles that those nerves serve, electromyograms and nerve conduction velocity studies.
Q Electromyogram, is that what they call an EMG sometimes?
A EMG. EMG and NCV, nerve conduction velocity studies.
Q I didn't see in your records whether or not you had performed any of those tests --
A Did not.
Q -- an MRI or --
A Did not. And I didn't have access to any records that reflected whether he had

72

had those done.
Q Do you know whether or not he had had those done? Have you heard?
A I don't know.
Q If he had had those done, or if he does have those done, particularly in a patient who has nonradicular complaints of pain, would that be the best evidence for you, as a physician, to look at, in terms of determining whether or not complaints of leg pain are related to the problem with the back?
A Well, it's not really a straightforward answer. Possibly -- it will be the best answer I can give you. The purpose of those types of studies, specifically the EMG/NCV, is to determine the normalcy or abnormalcy of a particular nerve root at a particular level in the spine or more peripheral nerves, and the effect that those nerves have, if any, on the muscles that they're serving, if there's any -- what the normalcy or abnormalcy of that response is.
Certain assumptions are made that, if

there is, say, a disc or a spur in the part of the spine where that particular nerve exits that's being tested, and there's a problem with the nerve, that they are related. One would assume that.

Q As a physician, when you have access to studies like that, like an MRI that you were talking about, when you have access to studies like that to review, when asked to state an opinion about the cause of a particular problem or complaint, does that put you in a position to state your opinion with more certainty?

A Well, in a sense, if the question is, with someone who presents with left leg pain, and an MRI shows a protruding or bulging or herniated disc in the lower part of the back, in the lumbar spine, that pokes out more on the left side at a particular level, and seems to pinch or impinge on a particular nerve root, then I would be able to -- in my mind, to my best medical judgment, would say that, assuming that the leg pain that we're talking about follows the distribution of that particular nerve root,

and the fact that the nerve root is being pinched by whatever it is that's pinching it, that those two are related.

However, it would be impossible to say what the cause of the spinal problem is. In other words, where did the disc come from? Where did the spur come from? It would be impossible to say that.

Q In terms of connecting it to a particular event?

A Event. Yes.

Q Okay. Now, other than, say -- you talked about, I think -- you used the word, I think, herniation or disc bulge or a pinching a nerve.

A Right.

Q I think these are terms that have come up. Other than that particular, you know, mechanism in the body, are there other things that can cause a person to have pain similar to the complaints that Mr. Sasser reported to you?

A Uh-huh.

Q What are some of the other things that can cause that, in terms of, you know,

bodily conditions?

A As far as back pain, there are a lot of things in the back. There are muscles. They can hurt. There are joints in the spine. They can cause pain. The discs themselves can cause pain. The effect of a bulging disc or an overgrown joint capsule or degenerated disc, any of these things can cause problems with nerves, which can cause pain. So, there are a lot of things that can cause back pain and leg pain.

Q Now, he didn't just report pain to you. Did he also report numbness or a loss of sensation in his legs?

A On exam, as you referred, there was, in our report, the nondermatomal decreased sensation to light touch.

Q Now, your records, I believe, also reflect a number of other health problems that Mr. Sasser has had treatment for. And I guess the best place to -- since you're looking back at your records -- to turn to, might be your initial office note.

A Right.

Q Could you summarize some of those

conditions that he reported to you as also having?

A Occasional angina, which is heart-related chest pain. Angina on exertion. Occasionally mild at rest. Congestive heart failure. He reported having had a heart attack or a myocardial infarction in 1996. In 1998, he had a coronary artery bypass graft operation, and, according to him, apparently had a valve problem, but I don't know the nature of that. He didn't have any valve surgery. He also reported decreased renal function, or kidney function, as a result of his high blood pressure.

Q Okay. Do you know the mechanism of how that works? How you could have renal problems, kidney problems, resulting from high blood pressure?

A Sure.

Q What is that? How are those connected?

A Well, any part of the body that doesn't receive adequate blood supply, the cells don't do well. They don't function normal. And that's, you know, renal

insufficiency, hepatic insufficiency, whatever part of the body.

Q Are kidney problems sometimes related to numbness in the extremities?

A Well, not being a nephrologist -- I suspect, in their literature, one might find that. But I don't focus on that, so I can't answer that question. I wouldn't take my answer as being an expert medical opinion on that issue.

Q Fair enough. How about the congestive heart failure? Are you in a position to state an opinion with regard to that?

A Well, congestive heart failure can lead to swelling of the extremities as a result of fluid buildup, fluid retention, which can be painful. But those, typically, are more distal towards the feet and ankles, lower part of the legs, can come all the way up the thigh. But that would be -- if there was enough edema to cause pain, it would be obvious that there was significant edema. Plus, the typical complaint of the nature of the pain is different than it is with pain as

a result of a back.

Q Can diabetes also be related to numbness in the extremities?

A Uh-huh.

Q Is that a "yes"?

A Yes.

Q We're taking it down on paper.

A Yes. You didn't hear the rattle, my head shaking?

Q I got it. I don't know if the court reporter did. Do you know whether or not Mr. Sasser has ever been tested for diabetes?

A I don't know that.

Q Is diabetes, to your knowledge, often related to renal insufficiency?

A Can be. But what the statistical correlation is, I can't say.

Q Is pain management a relatively new field when you compare it to other medical specialties out there? Or how long has it been around? Rather than asking you -- we can put an objective point on it. How long has the board been around?

A The concept of chronic pain, as an

entity, dates back to the end of the Second World War. However, as a medical subspecialty, as a medical specialty subspecialty, it has really come into its own in the last 20 to 25 years.

Q Are there objective medical findings that physicians can use to determine whether or not pain exists or not or where the pain is? With a broken bone, we can use an X-ray. With a nerve, we can use an MRI. Is there anything like that in the pain management field?

A No, not today.

Q And that puts you, as a physician, in a little bit of a different position, then, as opposed to an orthopedic surgeon, for example, in terms of what you have available to you in order to diagnose and treat a condition?

A In a sense.

Q Is pain management successful in 100 percent of your patients?

A No.

Q I'm not going to ask you to put a statistical figure on it, unless you happen

to have that in your head. But there are some patients who simply don't respond to the modalities and the treatments that you have available. Is that a fair statement?

A That's fair.

Q And that can be for a number of reasons? Would that be --

A That's fair to say.

Q Have you had patients that you've treated where you concluded that pain management was not getting them anywhere?

A I have.

Q Okay. And how long would you treat those patients before you made that determination, before you felt comfortable with the fact that we're getting nowhere?

A I can't say.

Q Okay. Is there a range that you think would be -- a minimum that you would want to stick with a patient and work on different treatments before you drew that conclusion?

A I can't say.

Q In order to reach that conclusion that the pain management was not helping,

would you rely mostly on the patient pain scores, or what would you rely on?

A A number of things. First of all, in order for me, personally, to reach that sort of opinion, I would have to feel comfortable and confident that I have tried everything that I know how to do for a particular pain problem, regardless of what those modalities included, and that the patient has not responded.

And by that, I mean, referring back to sort of the triumvirate of our goal, that being, reduce pain, subjective complaints of pain, improve function, and improve quality of life. If the patient can't give me feedback to make me believe that any of those have been achieved, then I would have to say that pain management has not been successful in a given patient.

How long that takes -- it may take two months. It may take two years. Sometimes it takes a long time to go through the whole gamut of possible treatments. So, it's just not -- and sometimes it takes even longer than two years.

Let me also say that we don't ever expect to get somebody pain free. It would be nice to hope that that would happen, but we don't expect it. We hopefully get the patients to understand that we don't expect that. Because, sometimes, they come to us expecting that. And in someone who never gives up that belief, that's a person that would have a difficult time getting any benefit from what we have to offer. We don't have many of those. Most people are pretty realistic about what they expect to get out of what we have to offer.

And there are patients that we see, that I've seen for years and years and years, who are no better than they were to start with, in a sense. In other words, their complaints of pain continue, but they're certainly no worse, and they continue to function, they continue to be able to be involved in family life, work, in some cases, enjoy recreation, those sorts of things. I consider that to be a successful outcome.

Q Do you consider counseling or psychological or psychiatric treatment to be

a useful component in a pain management program?

A Yes.

Q And do y'all employ that or do you have a referral system --

A We do.

Q -- or something like that?

A We do.

Q Do you do that with all of your patients, or with some, or how does that --

A Some, not all.

Q Based on your records, can you determine whether or not counseling or psychological or psychiatric services were recommended or employed in the course of your treatment with regard to Mr. Sasser?

A Part of our workup for our new patients involves what's called an MMPI, or Minnesota Multiphasic Personality Inventory. We use a particular psychologist here in town, primarily because he enjoys working with chronic pain patients.

I have, in Mr. Sasser's record here, an MMPI form and a request for an appointment. However, I, unfortunately, don't have the

results of that.

Q Do you have a date on the request?

A Well, I have a -- let's see. On this particular -- this is a computer sheet that has those little circles that are filled in. The test date is 3-19-02. And it was faxed on 3-20-02 and received on 3-20-02 from Dr. Jacobs' office. But, unfortunately, I don't have a result back on that.

Q Does the lack of having a result back on that, does that tell you, one way or the other, whether or not that was followed up with or whether or not the evaluation took place or anything else, or is it just an open question?

A It's an open question. Let me also say that, just by way of expounding on that, that our request for the MMPI doesn't imply in any way that we think that there is psychological motivations in a patient's request for our services. It's just part of what we do.

Just also let me say that chronic pain is a very complicated issue. There's certainly the physical component, which, in

many cases, is the genesis of all -- the whole picture. But chronic pain also has an affect on a lot of aspects of a patient's life which can't be objectified. It's strictly subjective. And all of those things, regardless of what they are, have an impact on patients' abilities to function and enjoy life, et cetera.

So, the MMPI really gives us some insight into some those factors which may be impacting the patient's ability to regain function or enjoy life. It won't tell anything about what kind of physical modalities might help. It's not intended to tell whether the patient is a malingerer. That's not the point of it. That's not what we use it for.

Q It's just an example of you trying to treat the whole patient as opposed to just putting a Band-Aid on it?

A Right.

Q Now, earlier, you testified -- well, actually, let's start back with looking at your initial intake record from September 5, 2000. We've used the term "pain scale."

And I don't know if I was the one who used that. You might have used it in your testimony. But I want to make sure that the jury is clear what that means, in terms of a pain scale. What is that? Is that as a diagnostic tool that you use in evaluating patients?

A Well, it's not really a diagnostic tool. Again, it's subjective.

Q Right.

A You alluded earlier to subjectivity of pain. And it certainly is. It basically is a ruler, so to speak, that allows us to get a relative point of reference for a particular patient.

Typically, when we describe the pain scale to someone to help them tell us where their pain is, we use a zero to ten. There are others. But we use a zero to ten. Seems to be the easiest one for everybody to grab hold of.

And the way I describe it is that zero is no pain, and ten is the worst pain that you can ever imagine. And we can't say specifically what that ten means, because

everyone's experience is different, and everyone's -- and that's based on a lot of different things. But, in general, everyone can think of something in their life that was the worst pain that they can recall, whether it was childbirth, having your finger caught in a door, whatever. Zero, most people can relate to. Nothing.

So, what we ask the patient to do, then, is to say where along that scale, zero, one, two, three, four, et cetera, their pain is. It gives us an idea of what they think their pain is at that time. And it changes from day to day. Changes from morning to afternoon. It changes from one minute to the next, sometimes. Where their pain is right then. Because, tomorrow, it won't be the same. It might, but it likely won't be. So, even though it's a number, it's still subjective.

Q Right. And zero on the scale, as a physician, I guess you can assume is fairly uniform across the board, from one patient to the next?

A Well, I would say nothing is pretty

uniform.

Q But the ten, at the other end, is something that's based on that patient's own personal experience?

A Yes.

Q And you explain this pain scale to the patients before they assign a number in their initial office visit?

A Yes.

Q Explain it kind of the same way you just did for the jury?

A I did.

Q On September 5, 2000, did Mr. Sasser give you a number on his pain scale?

A He did.

Q And what was his number?

A His number, at that time, was a six out of ten.

Q And I believe you testified that, by 2004, he was in the range of five, six or seven, which you characterized as the middle range?

A Yes.

Q Is that also true?

A Uh-huh.

Q And that implies reasonable pain relief?
A To me.
Q On September 5, at his initial visit, was that information taken from Mr. Sasser before any treatment was administered by your office or after?
A Before.
Q I want to change gears a little bit and ask you about this Intracorp letter that I believe is one of the records in your file in front of you. That letter that's dated 5-25, 2004.
MS. SHUMATE: I'm sorry. I thought he said that was not contained in his record. He has a July.
Q What's the date on the one in your record, just so I'm clear? I don't want to misstate it or act on a wrong assumption.
A 7-12-04.
Q Okay. And you were reading from that earlier. And at the end of the letter, you made a reference to some kind of appeal. Could you read that out for me, so I can be sure I have the language right?

A It says -- this is the last paragraph of page one. "If you have additional clinical information which documents the medical necessity of the service, you may appeal this determination by submitting a written request providing the additional information. Please send the appeal for request" -- and they give the address.
Q Okay. And is it your understanding that the letter indicated their opinion of a lack of medical necessity for the treatment that they were reviewing, for the proposed treatment they were reviewing?
A Would you repeat that?
Q Is it your understanding from reading the record that they concluded the recommended treatment was not medically necessary?
MS. SHUMATE: I object to the form of the question.
A Well, I would assume that.
Q Let me ask you this way. You have the letter in front you, and it's not a long letter. What is your understanding regarding

their conclusions in that letter?
A Well, it's not -- the implication, as I read it, is not that the treatments aren't appropriate. It's just that -- and I'll just quote. "It has been determined that the medical information provided does not support established standards of medical necessity." I have no idea what their guidelines are. So, what I take that to mean is that they felt that the documentation was inadequate, by their guidelines.
Q By their guidelines. And does it make a reference --
A Not that he didn't need treatment of some sort, but that, based on what information they had provided and their guidelines, that it didn't determine suitability.
Q Right. Okay. And did that letter say that your office could request a copy of their guidelines?
A It does say that.
Q Okay. And the letter also says your office could submit additional documentation concerning the medical

necessity --
A It does.
Q -- of the recommended treatment?
A It does say that.
Q Does anything in your file indicate that your office made any communications or sent any documentation to Intracorp following that letter?
A There is nothing in my chart that reflects that.
Q Has your office had to deal with these type of peer reviews or these outside review companies from time to time, just in the course of the business end of your practice?
A Yes.
Q And you, as the physician, are you kind of the first point of contact with regard to those companies, or do you have office staff who sort of process that daily paperwork?
A Well, the mail doesn't come directly to me. But, typically, if there's a request for further information or notification of a peer review or whatever, I

eventually receive it. And it's up to me, ultimately, to take it from that point on.

Q There is a, I guess, process, and kind of a flow of the paperwork when it comes in the office and comes to you? Is that right?

A Yes.

Q And when all things work as planned, all of the records come and are presented to you? Is that right?

A Yes.

Q Aside from the way things are supposed to work, do you have an independent recollection of getting that particular letter from Intracorp?

A This one?

Q That's right.

A Well, other than I see it here in front of me, no.

Q You see it here in front of you in --

A I don't recall the day it came to my desk.

Q Right. You see it in front of you in 2007. You don't remember having that

record brought to your attention in 2004 by your office staff?

A Not specifically, no.

Q You would have preferred it to have been brought to your attention? Is that right?

A Well, it may have been.

Q And it's your understanding, since it's in your record, that it did reach your office?

A Obviously.

Q And would you have preferred your office to have followed up with that letter by requesting the guidelines from Intracorp and/or submitting additional medical records to Intracorp in order to address that letter?

A Typically, yes.

Q Is that something that your office does from time to time with patients when there's a letter from a payer questioning the need for a service? Does your office sometimes forward additional information to that payer in order to justify your opinion and your recommendations?

A Sometimes.

Q And when your office does that, does your office sometimes get favorable responses?

A I would assume. Basically, a patient shows up, I work with the patient, the patient goes home. What happens in between all that, I usually don't know about. I'm assuming, if they're here, everything that's supposed to be approved is. I'm assuming that, if they're here, they're here for a legitimate reason.

Q Now, I believe one of your office records indicates that Mr. Sasser received several injections, all the way up until 2003. Were those lumbar steroid injections?

A No. The only injections that I provided for Mr. Sasser were trigger point injections in his legs, in various muscles of the legs.

Q And when was the last series of injections your office provided for him?

A 5-20-04.

Q 5-20-04.

A Uh-huh.

Q Do you have a record of anyone else

providing lumbar steroid injections?

A I don't have records. But Mr. Sasser, in my note of 1-20-03 -- let me make sure I have given you the correct date. But I believe that's right. Yeah. I had already referred to this earlier.

1-20-03, I had made a comment that the patient had had five to six lumbar epidural steroid injections without benefit. But I don't have any records where he had them done. This is simply a report by Mr. Sasser.

Q I see. Do you have any outstanding bills for treatment of Mr. Sasser? Bills that haven't been paid?

A I don't have any idea. I try not to get involved with that.

MR. KNOTT: I may have some additional questions after Amy. She indicated earlier that she already knew she had some rebuttals before I even started asking. So, I'll let her take over.

EXAMINATION

RESUMED BY MS. SHUMATE:

Q Do you have someone in your office, at that time or now, named Brenda? A lady in your office named Brenda?

A There was a secretary named Brenda.

Q Would she have been dealing with --

A I have no idea.

Q Okay. So, if Mr. Sasser talks about having called Brenda at your office, and she was dealing with Intracorp, trying to get it paid, would that give you some concern, or would that be something you would expect your patients to be dealing with somebody like her on these type problems?

A Yes.

Q All right. Now, I do have a couple of follow-ups. He asked you about MRIs and EMGs and NCVs, would that be the best evidence. And I think you -- it's fair to say that it doesn't hurt to have the most information possible? Is that correct?

A That's correct.

Q The lack of your having had them at

the time, does that change your opinion about what you testified about his back pain and the necessity for the treatment and that kind of thing?

A No.

Q Now, if, in fact, I do show you that he had an MRI, in 1997, that showed some impingement on the L5 nerve roots on the lateral recesses bilaterally, not to be significantly changed from February of '96, no evidence of disc herniation, basically a lumbar MRI which was consistent with degenerative disc disease, and he also had a nerve conduction study performed by a neurologist, that showed chronic bilateral L5-S1 radiculopathy -- and these took place before you ever saw him. Because he had been treated for five years before you ever saw him.

A Right.

Q Do those two tests, what I read to you about those tests, change your opinion in any way?

MR. KNOTT: Object to the form and the predicate. And I'll just

put on the record that he doesn't have those in front of him --

MS. SHUMATE: Sure.

MR. KNOTT: -- to review the entire record. That the question is based on the summary.

Q Assume, hypothetically, that the -- I'll ask again. Assume, hypothetically, that the results of the nerve conduction study and EMG report, which are done by Hassan Kesserwani, the results read -- assume this is correct. The results read, "1. There is no evidence of polyneuropathy. 2. There is no evidence of carpal tunnel syndrome. 3. There is evidence of a mild chronic bilateral L5-S1 radiculopathy."

And then, assume he had an MRI in 1997 that showed impingement on the L5 nerve roots on the lateral recesses bilaterally, with no evidence of disc herniation.

Assume those statements are true, that there were MRIs and EMGs that said those things. Assume hypothetically. Does that change your opinion in any way?

MR. KNOTT: Object to the form and foundation and predicate of the hypothetical.

A Would you mind specifying what opinion you're asking --

Q The opinion I asked you about, whether he has back pain, in your opinion, that he's not faking, whether the treatment that you gave for him was necessary and related to that back pain, whether the problems with his legs, the pain he's having in his legs, and the need for the trigger point is related to a back jury.

A It does not change my opinion.

Q Do those tests bolster any of your opinions, in your mind, the fact that he had those and they showed those results? I should say, are they consistent with what you saw? Not bolster.

A Hypothetically --

Q Yes.

A -- if those MRI results and EMG/NCV results are present, and, hypothetically, someone reports back pain and leg pain, then, hypothetically, there can be a relationship.

Q And you were asked about angina, coronary artery disease, kidneys, high blood pressure, diabetes. In your medical opinion, are any of those conditions the cause of his back and leg pain?

MR. KNOTT: Object to the form and the predicate and the foundation of the hypothetical.

A Unlikely. I would have to say no.

Q Thank you. Now, the pain scale that he indicated he had a six out of ten, that's that one question that one day? Is that correct?

A Right.

Q In your opinion, was the four years of treatment -- almost four years of treatment you rendered for Mr. Sasser, until it was cut off in May of '04, was it a successful pain management regimen for him, in your opinion?

MR. KNOTT: Object to the form. Foundation.

A Well, it really, I guess, depends on how you define success. Success that his pain scores didn't go up, that his pain

didn't make him -- that they didn't get worse, that he didn't become more debilitated as a result of his pain, I can't say, because the only way to say that would be to go back and go to that same time frame and remove all the medication.

So, does the reporting of a pain score on the last day of the visit of a five out of ten versus a pain score on the first day being a six out of ten imply success? Does it imply that he didn't get worse? I don't know.

Q Well, I guess that's what I'm trying to get at. I guess the implication could be, well, it's not necessary and it's not helping him, because it only went from a six to a five, from the beginning to the end. But, am I correct that that's not your judge of success nor Mr. Sasser's indication to you that this wasn't helping him any, was it?

MR. KNOTT: Object to the form.

A I can't speak for Mr. Sasser's mind.

Q He kept coming back.

A Well, one would assume that if

there is a series of events that's ongoing, repetitive and routine, that if it's unsuccessful or just not something that somebody wants to do, that they will stop at some point along the way. That's what I would assume. I can't answer how someone else would operate.

Q You did not come to the conclusion during this time period that pain management was not helping him, did you?

A I did not come to that conclusion.

Q And you did not cut him off yourself, saying this isn't working, did you?

A I did not.

Q In fact, you anticipated he would continue with pain management for some indefinite period of time?

MR. KNOTT: Object to the leading.

Q Is that correct?

MR. KNOTT: Object to the leading.

Q He had another visit scheduled?

MR. KNOTT: Object to the leading.

A I intended for Mr. Sasser to continue coming here, because I have a note here on his trigger point injection procedure

note of 5-20-04, in which I report "Follow-up already set." So, my assumption is that we had requested the next appointment.

Q Okay. Do you have patients who treat with you for years, and it's intended or expected they're going to treat with you 'til something miraculously happens or they die?

A Yes.

Q And that's part of the process of pain management? Am I correct?

A In our practice, yes.

Q Was there anything about Mr. Sasser that made you think that that was not going to be the course for him?

A Well, I can't say. I mean, I didn't anticipate stopping suddenly. But, obviously, at any point in time -- you know, I can't prognosticate what's going to happen at any time in the future. So, my intent was to continue treating Mr. Sasser as long as he needed it.

Q Is the history he gave you consistent with what you saw in him? I mean, was there something about the history he gave

you of the mode of his injury that made you go, hmm, that doesn't seem like what would have caused this?

A The nature of his injury as reported to me on the initial intake was consistent with the nature of the pain complaint at that time.

Q Is it consistent with the diagnosis that Dr. McGahan had given him of lower back pain, spinal stenosis, muscle spasms?

A Well, first of all, I would say that, hypothetically, Dr. McGahan's diagnosis of stenosis came from his receiving the hypothetical MRI.

Q That's correct.

A He, on physical examination, would be unlikely to make a strict diagnosis of stenosis just on physical exam alone.

Q That would be something an MRI would show?

A Yes.

Q That's the type of thing that an MRI would diagnose?

A Would show. Yes.

MS. SHUMATE: Okay. That's all.

EXAMINATION

RESUMED BY MR. KNOTT:

Q Dr. Marsella, the question of his complaints being consistent with the story he reported to you, his story could also be -- or his complaints could also be consistent with a number of alternate or other explanations for how that pain came to be? Is that right?

A That's correct.

Q In other words, your records reflected lifting something at the G. E. plant?

A Correct.

Q And that's one thing that could coexist at the same time as his pain. That's one possible explanation, I guess is one way to say it?

A Well --

Q Is that what you mean when you say "consistent"?

A No.

Q That's a possible explanation?

A Consistent, when I use that term,

when "A" is consistent with "B," means that the report of, in our case, pain, makes sense based on the report of some event. So, that's what consistent means. Doesn't mean that it necessarily, 100 percent, without question, that there is a causative relationship.

But, based on the nature of a particular event and the nature of a particular complaint, if it's reasonable -- if I oftentimes see "B" as a result of "A," then my experience leads me to believe that there's a relationship.

Q But, as you testified earlier, it's impossible to say, with certainty, that "A" caused "B" in a case like this, where you have a 1995 accident, and you saw him in 2000 with this presentation?

A Well, when a patient says -- when we ask, "When did your pain begin," and they give a date, day or date or whatever, and we ask them what caused that, and they give an event, we assume that the pain that they present, that started on a given day, and the event that it happened on a given day, is

related. The assumption is made. I don't usually ask, "Well, have you ever had" -- well, no. I shouldn't say I don't usually ask. But, if somebody says to me, my pain began on this day, then I assume that that pain wasn't there before that day. Do you follow what I'm --

Q I do. On the other hand, a report by a patient like Mr. Sasser, reporting that a particular event caused his condition, it would not change the way you treated that condition -- right? -- because you're treating the condition?

A That's correct.

Q It's not based on the event that caused the condition? Is that fair?

A That's fair.

Q And so, although you, as a physician, will assume that the patient's report is correct, it's not a medically-necessary determination that you're making in terms of whether the patient's history is accurate in terms of this event caused the condition. That's not a medically-necessary determination you make,

because it wouldn't affect your treatment. Is that also a fair statement?

MS. SHUMATE: Object to the form of the question.

A I'm going to rephrase your question.

Q Okay.

A And make sure I rephrase it correctly. What you're asking me is, would it have mattered, the causative event, whether it was a sneeze or lifting whatever or twisting, you know, catching a 400-pound marlin or whatever. Would it have mattered how I treated the patient, based on presentation of pain complaint? The answer is no. I don't treat the cause. I treat the effect.

Q And to extend that answer a step further, the cause of the condition, it's not medically necessary for you, as a physician, to determine the cause?

A That's correct.

Q And so, although you're able to assume that a patient's report to you is accurate, that's not the primary goal in your

treatment, to determine whether the patient is accurate in reporting what caused the condition?

A That's correct.

Q And so, that's not a conclusion that you, as a physician, reach with medical certainty, whether or not an event caused the condition, because it's not a medical opinion?

MS. SHUMATE: Object to the form of the question. He could reach that opinion if he's asked.

A That's sort of a -- to me, sort of a multipart question.

Q Okay. If you can break your answer up, then that's --

A Certainly. From the standpoint of, does the cause of a particular pain condition, regardless, have any impact on how I treat a given pain condition, no.

If asked for an opinion about whether a particular event caused the onset of a particular pain condition, it doesn't matter -- I can say "yes" or "no," given the right -- you know, given the information, but it

wouldn't matter how I treated that pain condition.

So, yes, I can offer an opinion about cause and effect, but it doesn't matter what I do. It doesn't matter in what I do, is what I should say.

Q I believe, earlier, you testified that it's impossible to say, with certainty, whether this particular event that was reported to you was, in fact, the cause of the conditions that you treated Mr. Sasser. And if there's a question about that, we can -- the court reporter can read it back. Do you remember your testimony that way?

A No. I don't remember.

MS. SHUMATE: Object to that question.

Q Okay. Should we read that back?

MR. KNOTT: Do you remember where that was?

COURT REPORTER: I certainly don't. I don't know how long it would take me to go through all the notes.

Q Setting aside for a moment the

question of the event that caused the conditions, is it your understanding that Mr. Sasser has been diagnosed with degenerative disc disease in his lumbar spine?

A Well, if a hypothetical MRI can be relied upon to relate to a specific patient -- is that possible? I mean, is that allowable? As I understand it, in earlier questioning, an allusion was made to an MRI, but then it was hypothesized later that, if an MRI showed this.

Well, if I had an MRI report that had Mr. Sasser's name on it, and I read the report, and it said that there was degenerative disc disease, then I would say that the patient has degenerative disc disease. So, does that answer your question?

Q Degenerative disc disease can have a number of causes? Is that right?

A Yes.

Q And it can also occur without any particular outside cause?

A That's correct.

Q It can be a condition that just naturally develops in the person's body as a

process of aging? Is that correct?
A That's correct.
Q And let me ask you about lumbar stenosis. Is lumbar stenosis also a condition that can develop without an outside cause?
A Well, stenosis is narrowing. So, that implies that the normal caliber of the spinal canal and the normal caliber of the openings out of the spine, called foramina, when those are smaller than they should be, that is stenosis.
Now, the stenosis comes as a result of something narrowing the caliber of those cavities, whether it's an overgrown capsule around a disc -- around a joint, whether it's a disc that's poking out, whether it's the fact that the spine bones come closer together as a result of the degeneration of the disc, whatever.
So, to extend that process, something is going on in structures surrounding the openings for the nerve roots, nerves, spinal cord, whatever. What that is doesn't necessarily matter. But the fact that there

is a narrowing, which is then known as stenosis, occurs.
If those events occur spontaneously or through the natural process of aging or whatever, injury, whatever, that results in stenosis, then, yes. If the event that caused the stenosis is spontaneous, then, in a sense, the stenosis can also be spontaneous.
Q And by "spontaneous," you're referring to what we were talking about in terms of degenerative disc disease?
A No distinct cause. A natural process of aging, or could be a series of events.
Q So, conditions like degenerative disc disease and lumbar stenosis can both occur in a person who has no injury, no accident or event at all?
A Sure.
Q And by looking at an MRI, a physician can't determine, necessarily, whether this person's degenerative disc disease and lumbar stenosis was caused by an event or caused by the natural process of

aging? Is that correct?
A That's correct.
Q And it feels the same -- is that correct? -- to the patient?
A I would have to defer to the patient.
Q Okay. And Mr. Sasser's complaints of pain and his physical complaints and the descriptions of how his condition felt to him, in your office, was that consistent with a person who had pain as a natural process of aging?
MS. SHUMATE: Object to the form of the question.
A I'm not real sure I understand your question. In other words, if you're asking me, just as the process of having more birthdays, would one have the kind of pain that Mr. Sasser presented with --
Q I don't mean necessarily.
A Right.
Q But, is it consistent with --
A Is it possible? Well, I can't answer the question the way you asked it.
Q Okay. Assume Mr. Sasser had not

told you that he had hurt his back lifting something in 1995. Without that one piece of verbal history from the patient, would your records give you anything to draw an opinion concerning any particular event being the cause of his condition?
A Well, with a complaint of low back pain and leg pain, and somebody said, "I have back pain and leg pain, and that's all I'm going to tell you. You know. Now your job is to find out how to help me," what I would do, is, if I couldn't -- if I didn't have access to previous studies like MRIs, EMGs or other X-rays or things like that, I would order them to determine.
Because the nature of a complaint -- oftentimes what we see is the particular nature of a complaint goes along with some physical finding, radiographic, electrodiagnostic, whatever. So, then I would try to find if there was a reason for that type of pain, stenosis, degenerative disc disease, whatever.
So, to say, does everybody have low back pain and leg pain as they get older, no. To

117

ask, is onset of low back pain and leg pain consistent with getting older, or could it be the result of getting older, not in and of itself, I don't think. There usually is some reason, typically spinal reason, for specific complaints of low back and leg pain.

Q And in this particular case, where you did have Mr. Sasser giving you his own account of lifting something in 1995, you felt it was adequate to rely on that, and did not go back to request or order MRIs or NCVs or EMGs? Is that correct?

A That's correct.

Q Have you met with Mr. Sasser's attorney, Ms. Shumate, before today?

A On this case?

Q Yeah. On this case, I suppose. Yes.

A I don't recall.

Q Or had any communications with her?

A Not that I recall, no.

Q Do you charge a fee for giving this deposition in this case?

A I do.

Q And what is that fee?

118

A We charge $1200.00 an hour.

Q Okay. Do you know whether Mr. Sasser has had treatment by any neurosurgeons or neurologists?

A I don't know that.

Q Do you think a neurosurgeon with access to MRIs or NCVs or EMGs would be in a good position to form an opinion with regard to the nature and cause of the type of conditions that Mr. Sasser reported to your office for?

MS. SHUMATE: Object to the form of the question.

A I can't say specifically. I would assume that a surgeon, neurosurgeon, who has access to MRIs and EMG/NCVs of a patient would be able to relate the physical findings on those studies to the nature of a pain condition.

But, as to the cause of the physical findings on the studies, unless there were similar studies prior to a given event that you could compare, then I don't know that you could make -- I can't imagine anybody, neurosurgeon or anybody, being able to state

119

an opinion as to cause/effect.

Q Do you get patients referred to you by neurosurgeons?

A Yes.

Q And when that happens, is there some sort of exchange of information between you and the neurosurgeon?

A Typically.

Q And so, are you, I guess, in the business of relying on neurosurgeons' opinions in this regard to a certain degree in your medical judgments?

A Yes.

MR. KNOTT: That's all I have right now. But Bill had made an objection to the deposition before, in his letter to you, and I'll reserve the right, on the basis of that objection, and based on the --

MS. SHUMATE: He didn't object to the court. He wrote me a letter and said, if you're going to use him as an expert, I'm going to object to the

120

court. And I said, if you're going to object, please do so before I pay Dr. Marsella. And there was no objection given.

MR. KNOTT: And I'm going to reserve the right --

MS. SHUMATE: You can object to any evidence at the trial. I mean, that's your business.

MR. KNOTT: I'm going to reserve the right to continue this deposition at a later date, on the basis of the lack of designation of Dr. Marsella as an expert in advance of the deposition.

MS. SHUMATE: You can reserve the right to ask the judge to let you come back and take it all you want. I'm not going to agree to any kind of reservation of you continuing this for that purpose.

MR. KNOTT: And that's on the record.

MS. SHUMATE: Thank you. I have one question.

EXAMINATION

RESUMED BY MS. SHUMATE:

Q In this case, you didn't rely on any neurosurgical opinions, because there were none provided to you when you were treating him? Is that correct?

A That's correct.

Q And when you rely on the opinion of a neurosurgeon or a neurologist, it's on a case-specific basis for that particular patient? Is that correct?

A That's correct.

Q You would not, in this case, defer to some neurosurgeon, neurologist, pain management, anybody else's opinion, just because they reviewed records and had a different opinion with you regarding Mr. Sasser, would you?

A No.

MS. SHUMATE: Okay. Thank you. That's all.

EXAMINATION

RESUMED BY MR. KNOTT:

Q Would you defer to the opinion of a physician who had, at his disposal, additional records which were not at your disposal?

MS. SHUMATE: I'm going to object to the form of the hypothetical. You haven't laid a predicate for it properly.

Q I believe plaintiff's attorney asked you to assume certain studies had been performed on Mr. Sasser. If a physician had, at his disposal, studies of that nature regarding a patient, regarding Mr. Sasser, would you defer to that physician's opinion, if that physician's opinion was informed by those additional studies?

MS. SHUMATE: Object to the form of that question.

A Well, I wouldn't defer to the opinion as far -- defer to an opinion as far as cause and effect. I would certainly take any additional information, such as

radiographic studies, magnetic resonance imaging studies, electromyographic studies, as supportive evidence of the nature -- of the cause of the nature of the pain. But as to the cause of the findings of the studies, per se, another physician's having that information wouldn't make any difference, in my opinion, about the patient's pain condition. Does that answer your question?

Q And, specifically, when you refer to your opinion regarding the patient's pain condition, what do you mean by that, just for clarity?

A Well, low back pain and leg pain.

Q So, it wouldn't change your opinion regarding the fact that he's having leg pain and low back pain?

A It would just substantiate it.

Q It would substantiate it.

A That it's a reasonable pain response to a physical finding on diagnostic study. In other words, the presence or absence of spinal stenosis, degenerative disc disease, doesn't, in and of itself, necessitate the presence of back pain, leg

pain. The fact that they're both present at the same time is consistent.

Q Assume a physician were to review the MRI findings and conclude that the findings of the MRI were not consistent with the nature of subjective complaints, as being the cause of those subjective complaints. Would you defer to an opinion such as that being based on a neurologist reviewing an MRI finding?

MS. SHUMATE: Object to the form of the question.

A Not necessarily. Opinions are opinions. I mean, we form our opinions based on lots of things. But, you know, what another physician's -- not to say that I don't appreciate input from other physicians, because I rely on that heavily in some cases. Whether I will throw my opinion out the window and say, well, whatever you say is right, I wouldn't normally do that.

Q If my question implied that another doctor was better at forming the opinion, then that's not what it was meant to imply. But, in terms of the information that opinion

would be based on, if a neurologist were able to review an MRI that you had not had the opportunity to review -- and assume a neurologist did review the MRIs that you were not able to personally review.

And assume further that that neurologist or neurosurgeon concluded, based on the review of that MRI that you had not had the opportunity to review, that the neurologist concluded that the MRI findings regarding the patient's back were not consistent with the patient's complaints -- with being the cause of the patient's complaints in his leg.

Would you defer to that opinion as being based on more information that was not at your disposal?

MS. SHUMATE: Object to the form of the hypothetical.

A Assuming that the nature of the pain complaint to the neurologist and the nature of the pain complaint to me were exactly the same, I would consider it. I can't say whether I would defer to it or not, because that situation wasn't present.

Q And in considering it, I guess,

would it be appropriate for you, at that time, to withhold judgment until you had the opportunity to review those same MRIs that the neurologist or the neurosurgeon had reviewed, so you could formulate your own opinion based on that evidence?

MS. SHUMATE: Object to the form of the question.

A It would certainly be nice to have the data available.

Q And that's something that you think would be appropriate to do in that eventuality?

A Yes.

MS. SHUMATE: Object to the form of the question.

Q Was that a "yes"?

A Yes.

MR. KNOTT: That's all I have right now.

EXAMINATION

RESUMED BY MS. SHUMATE:

Q Assume, hypothetically, that there

was a workers' comp case filed. A man claims he got hurt on the job. He settled his case with the workers' comp company. And part of that judgment, in a court of law, is that they are to continue to pay for medical treatment related to his back injury.

Assume also, subsequent to that, several years after that, there's a dispute as to whether his complaints and his treatment is related, and the judge enters a second order saying, I find he was injured on the job, in his back, in September of '05, and Dr. McGahan relates that to his work, and, thus, they are responsible for future medicals for that low back injury. And then, you see him starting in 2000 from Dr. McGahan referring him for that low back pain.

Based on those hypotheticals, are you treating him for the back pain he sustained, that Dr. McGahan said was related, that the judge has ordered was related?

MR. KNOTT: Object to the form and the predicate.

Q Is there anything different, to your knowledge, you're treating him for than

what he was sent here for by Dr. McGahan for that back injury?

MR. KNOTT: Object to the form and the predicate and the foundation. It misstates the factual record.

Q You can still answer the question.

A Assuming all that is correct --

Q Sure.

A -- yes.

MS. SHUMATE: Thank you. That's all.

(Whereupon, Plaintiff's Exhibits 1, 2 and 3 marked for identification.)

END OF DEPOSITION

PLAINTIFF'S EXHIBIT NO. 1

PLAINTIFF'S EXHIBIT NO. 2

PLAINTIFF'S EXHIBIT NO. 3

STATE OF ALABAMA
HOUSTON COUNTY

I, Stacey Watkins, RPR, and Notary Public, State at Large, do hereby certify that the foregoing transcript, pages 1 through 131, is a true and correct transcript of the testimony and proceedings taken at said time and place; and that the same was taken down by me in stenograph shorthand, and transcribed by me personally or under my personal supervision.

I further certify that I have no interest in this matter, financial or otherwise, or how it may develop or what its outcome may be. I further certify that I am not of counsel for any of the parties, nor am I related to counsel or litigants or associated with anyone connected with this cause to my knowledge.

Witness my hand this 24th day of July, 2007.

_____

_____
RPR, Notary Public,
State at Large

E

F

S